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When pandemics collide

One pandemic virus has been a major topic in global health for almost 40 years, the other was discovered just 4 months ago, but, as SARS-CoV-2 infections have now been reported in most African countries, HIV and COVID-19 are on a collision course. Although we have learned a remarkable amount about SARS-CoV-2 in a short time, its potential impact on people living with HIV and on health systems in settings with high HIV burdens is becoming a major concern.

Organisations including UNAIDS, UNICEF, and the International AIDS Society have begun to issue guidance and advice on how to deal with COVID-19 in high HIV burden settings. The Global Fund to Fight HIV, Tuberculosis and Malaria has also urged recipients to divert surplus funds to prepare and respond to COVID-19. We do know, however, that the response to SARS-CoV-2 is compromising HIV programmes. As global travel and transport are disrupted, drug supply chains are jeopardised. In a Comment, Weiming Tang and colleagues highlight the contributions of non-governmental organisations stepping in to ensure consistency in HIV care during the SARS-CoV-2 pandemic.

In Nigeria, as reported in a Feature by Paul Adepoju, the threat of SARS-CoV-2 is already having an effect on HIV and tuberculosis responses as patients choose to social distance by not going to health-care centres to collect drugs. Patients with tuberculosis in Ibadan have been reluctant to travel to collect drugs owing to the overlapping symptoms of tuberculosis and COVID-19. Indeed, clinical diagnosis of COVID-19 will be complicated by the high prevalence of tuberculosis, *Pneumocystis jirovecii* pneumonia, and cryptococcosis associated with high burdens of HIV—all of which may have respiratory or imaging characteristics that overlap with the new disease. For care providers in the region, this will be a challenge not yet experienced in other settings.

The responses to COVID-19 in low-resource, high HIV burden settings will necessarily be different from those in the high-resource settings largely affected so far; but a history of adapting to diverse and shifting HIV epidemics in adverse conditions should enable creative solutions to SARS-CoV-2 across sub-Saharan Africa. As James Hargreaves and colleagues point out in their Comment, despite the differences between the viruses, the HIV response has lessons for the COVID-19 response.

At the time of writing, sub-Saharan Africa has reported relatively few cases: several thousand in South Africa and just tens or hundreds in other countries. However, these numbers are probably substantial underestimates owing to limited testing capacity. A unifying factor of the countries that have managed to suppress SARS-CoV-2 outbreaks rapidly is large-scale testing and contact tracing. Where those facilities are not possible, sentinel testing to identify the worst affected areas might be one solution to make the most of limited resources.

South Africa acted rapidly by imposing a lockdown, banning the sale of alcohol and taking homeless people into facilities where they could be observed and where substance-use issues among the homeless can be managed. But social distancing is not always possible; many people in high HIV burden settings live in densely populated, cramped housing with limited access to sanitation. To help reduce transmission, Kenya has banned public gatherings, made the wearing of masks mandatory in public, imposed curfews, and set up isolation and quarantine centres for people who test positive for SARS-CoV-2 and their contacts, respectively.

Multimonth dispensing of antiretrovirals has been a topic of interest in recent years: in Kenya, South Africa, and elsewhere, provision of 3 month or even 6 month supplies of antiretrovirals at one time as a response to COVID-19 is becoming the norm to reduce clinical contacts and to facilitate social distancing.

In sub-Saharan Africa, systems put in place to deal with HIV and the resourcefulness that characterises the health-care response might be a great asset in the fight against the new pandemic. And the experience in fighting for fair access to new treatments may be more relevant than ever in the coming weeks. In the short term, SARS-CoV-2 will draw attention away from HIV, disrupt treatment and prevention programmes, and may lead to a rise in disease burden and even HIV incidence as a result. HIV programme directors should use their experience and creativity to gather and disseminate data on the impact of SARS-CoV-2 at the individual, community, and national levels. Now is also the time to start thinking about how to rebuild and reshape the HIV response once the initial wave of COVID-19 is passed and nations learn to live with the dual pandemic. ■ *The Lancet HIV*



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See [Comment](#) page e308

See [Feature](#) page e319

See [Comment](#) page e309

For [UNAIDS resources on COVID-19](#) see <https://www.unaids.org/en/covid19>

For [International AIDS Society resources on COVID-19](#) see <https://www.iasociety.org/covid-19-hiv>

For [Global Fund resources on COVID-19](#) see <https://www.theglobalfund.org/en/news/2020-03-04-global-fund-issues-new-guidance-in-response-to-covid-19/>

For [Johns Hopkins data on global cases and deaths](#) see <https://coronavirus.jhu.edu/map.html>

For the [Worldometer data on cases, deaths, and tests](#) see <https://www.worldometers.info/coronavirus/>